GENERAL INFORMATION – FORM WC-701

The form WC-701 (Form 701) is used to report to the Agency payment of weekly compensation benefits made to the employee. Attorney fees, rehabilitation costs, medical expenses, etc. should not be reported on the form. Burial expenses must be reported by the employer on form WC-106 or a receipt of payment will be requested.

The filing number should always be #1 the first time the Form 701 is submitted for a claim, and then increase sequentially for subsequent filings.

It is critical that all subsequent filings contain the **exact** SSN and DOI that were reported on the first filing. If this information was previously reported in error, the correction(s) should be clearly marked on the form.

Friend of the Court payments should not be reported to the Agency.

All Agency orders have a nine digit number written in the upper right hand corner consisting of the mailed date and a three digit sequential number. All Forms 701 that are filed pursuant to an award (basis of payment anything other than “A”) should have the order number included in the space provided below section D.

Redemption amounts should not be reported on a Form 701. If the redemption involves a claim which is in payment status, the system will automatically close out the weekly payments assuming that the weekly rate, date of injury and carrier listed on the redemption order match the information on the latest Form 701. If not, a Form 701 must be filed closing out the weekly payments. A Form 701 must also be filed if partial benefits are being paid at the time of the redemption.

Lump sum advance payment amounts should not be reported on a Form 701. If the advance payment order results in a reduction or termination of the weekly rate, a Form 701 must be filed showing the rate change or termination.

In February of each year, the Agency runs a program which closes all open paying claims as of December 31 and reopens them on January 1. Once that is done, an Open Claim Validation Report is sent to each carrier or service company listing all claims that closed and reopened as well as those that could not be closed because of an error. This report should be used to verify that all claims on the report are still in open payment status and that the rate is correct. If not, the appropriate Forms 701 should be filed. If partial benefits are being paid, the employee worked less than a 5 day work week, or the compensation rate is in error, a Form 701 must be filed.

Forms 701 which are filed to report payment of accrued benefits as a result of an order or agreement which cover multiple benefit periods should have the Report of Accrued Benefits worksheet (or a similar format) attached and include all available information: basis, benefit type, special payment, weekly rate, from and through dates and total amounts paid for each payment period. Interest payments, when applicable, should be reported on a separate line from the accrued benefit period(s) and include the special payment code, through date and total interest payment only.

FILING INSTRUCTIONS FOR FORM 701

PART A

This section must be completed when filing the Form 701. Extreme care should be taken to ensure that all subsequent filings contain the same correct SSN and DOI.

#1 Social Security Number: 9 digit numeric.

#2 Date of Injury: Must be complete date (mm/dd/yyyy).

#3 Employee Name: Employee's last name, first name and middle initial.

#4 Date of Birth: Must be complete date (mm/dd/yyyy).

#5 Date of Death: If employee is deceased, enter complete date (mm/dd/yyyy).

#6-9 Employee Address: Complete mailing address of employee.

#10 Employer Name: Enter complete business name of employer, d.b.a., etc.

#11 Federal ID Number: Enter 9 digit Federal ID number used by the employer listed in #10.

#12 Injury Location Code: This should be left blank. It is an internal three digit location code that is assigned and used by Agency staff only.

#13-16 Employer Address: Complete address of employer, including number, street, city, state and ZIP Code.

#17 Carrier or Self-Insured Name: Enter complete name of carrier or self-insured employer. A service company name should not be reported in this field.

#18 NAIC or Self-Insured Number: Carriers should report their 5 digit NAIC number and 4 digit group code, and self-insureds should report their 8 digit self-insured ID number.

#19 Self-Insurer's Service Company Name: Enter the name of the service company handling the claim. Enter the service company name **only** if the employer is an Agency authorized self-insurer. This line is to be left blank if a carrier has written a standard market policy or a large deductible policy.

#20 Service Company ID Number: The 3 digit service company ID number assigned by the Agency must be reported if a service company name is listed in #19.

#21 ZIP Code of Issuing Office: ZIP Code of carrier or self-insurer (or service company filing form on behalf of an Agency authorized self-insurer) filing the form. The ZIP Code will be used in conjunction with the carrier or self-insurer service company to identify the mailing address of the appropriate office where correspondence should be sent.

#22 Carrier or Self-Insured Claim Number: Submitter's claim or file number, if applicable. This number will appear on all system generated correspondence.

#23 Date Carrier Received Notice of Injury: This information is required on all voluntary payment claims to determine promptness of payment.

#24 Date First Payment Made: The date the first check was sent out on this claim. This date is required on all voluntary payment claims to determine promptness of payment. If the employer is continuing to pay wages while the compensability issue is being resolved or benefits are being coordinated under a wage continuation plan, the date first payment made should be the same as the from date in Part D.

PART B

This section must be completed when filing the Form 701.

#25 Nature of Injury: Provide a brief description of the injury or disease. If desired, the codes from the list of filing codes may be entered in addition to the description.

#26 Part of Body: Provide a brief description of the part of body affected by the injury or disease. If desired, the codes from the list of filing codes may be entered in addition to the description.

#27 Average Weekly Wage: Total weekly wages from place of injury, excluding fringes.

#28 Discontinued Fringes: Weekly fringe benefits that are not continuing during the disability period.

#29 Second Employer AWW: Total wages from second employer, if applicable.

#30 Second Employer Discontinued Fringes: Discontinued fringes from second employer, if applicable.

#31 Tax Filing Status on Date of Injury: Employee's tax filing status at the time of injury using the federal income tax eligibility criteria. The status does not change during the life of the claim.

#32 Last Day Worked: Last day preceding the current disability period for which the employee received full wages.

#33 Number of Days in Work Week: Number of days the employee is regularly scheduled to work per week. If the employee works less than a 5 day week, we are unable to calculate the total amount paid. Therefore, if any of these claims are in open payment status at the end of the year, a Form 701 must be filed reporting the amount of compensation paid during the year. All payments made for dates of injury on and after May 11, 1999 must be calculated on a 7 day work week per Rule 408.31a.

#34 Number of Dependents: Number of dependents, not including the employee.

PART C

This section must be completed when filing the Form 701. The information should always pertain to the latest payment period reported on the form.

#35 Reason for Filing: The appropriate code must be entered on all filings:

A – Commencing Benefits: Used whenever benefits are commencing and continuing. In Part D, complete the basis of payment, benefit type, special payment (if applicable), weekly rate, and from date.

B – Change in Weekly Rate: Used whenever there is a change in the current rate and benefits are continuing. In Part D, complete the entire first line (except for the termination reason) in order to close out the old rate, as well as the first half of the second line in order to report the new total weekly rate and from date. If benefits covered more than one calendar year, the from date on the first line should always be January 1 of the current year. When benefits are changing from partial to total, a wage statement showing the calculation of partial payments must also be attached to the Form 701.

C – Terminating Benefits: Used whenever benefits that were previously reported are now being terminated. In Part D, complete the entire first line showing the total payments made for the current calendar year only.

D – Commencing and Terminating Benefits: Used whenever benefits that have never been previously reported are both commencing and terminating. In Part D, complete the entire first line showing the total payments that were made.

E – Reimbursement by a Fund: Used whenever the rate is staying the same but reimbursements are now being received from either the Silicosis, Dust Disease and Logging Industry Compensation Fund or the Vocationally Handicapped Provisions of the Second Injury Fund. In Part D, complete the entire first line to close out the rate and payment period (if payments covered multiple calendar years, use January 1 of the current calendar year) for which the carrier is responsible, as well as the first half of the second line in order to give us the new from date for which reimbursement takes effect.

F – Reopening Claim: Used whenever a claim that had previously been in payment status is now reopening and benefits are continuing. In Part D, complete the basis of payment, benefit type, special payment (if applicable), weekly rate, and from date.

G – Reopening and Closing Claim: Used whenever benefits are both commencing and terminating on a claim that had previously been in payment status. In Part D, complete the entire first line showing the total payments that were made.

H – Yearly Report of Partial Payments: Used to report the amount of partial benefits that were paid on all claims which are in partial benefit status as of December 31. A wage statement should also be attached. This code should also be used when reporting yearly payments on any claim still in payment status at the end of the year in which the employee worked less than a 5 day work week. In Part D, complete the entire first line (except for the termination reason) in order to report the partial payments that were made during the previous calendar year (show the through date as close to

December 31 as possible) as well as the first half of the second line using a from date one day after the through date. A partial payment worksheet must also be attached to the form.

I – Error on Previous Filing: Used whenever information was improperly reported on a previous Form 701.

#36 Weekly Compensation Base Rate: The base rate which is owed prior to taking into account any adjustment(s) specified in line 37.

#37 Weekly Adjustments to Base Rate: This line should always be completed when the base rate in line 36 does not match the "total weekly rate" in Part D. Record the appropriate code(s) and weekly dollar amount(s). If the code is "A" thru "G" (coordination of benefits), the appropriate section in Part E should also be completed on the back of the form. If the code is "J" or "K," the order number must also be entered in the space provided below Part D. If the code is "R," rate reduction due to post injury wage earning capacity (PIWEC), Part F should also be completed on the back of the form.

#38 Weekly Amount Being Reimbursed by a Fund: Indicate the appropriate code(s) and weekly dollar amount(s) being reimbursed by the Silicosis, Dust Disease and Logging Industry Compensation Fund or the Vocationally Handicapped Provisions of the Second Injury Fund. Do not record any Compensation Supplement Fund payments (adjustment code of "I") or Second Injury differential benefits (adjustment code of "L"). These amounts should be reported in #37. Also, do not report any reimbursements received as a result of the 70% or Dual Employment provisions. This information will be provided to us by the Second Injury Fund.

PART D

This section must be completed as follows when filing the Form 701 on a claim.

BASIS OF PAYMENT:

Indicate the appropriate code from the list of WC-701 Filing Codes. When a claim is being paid pursuant to any type of order, including a voluntary payment form (WC-115), include the order number in the space provided below Part D.

BENEFIT TYPE:

Indicate the appropriate code from the list of WC-701 Filing Codes. This information is always necessary unless a Special Payment type code is present. Also, the first filing reporting a specific loss benefit type "C" should include a copy of the amputation chart signed by the physician or affidavit of vision loss, whichever applies. The number of loss weeks and effective date of loss should be completed below Part D.

When the benefit type is "D" (permanent total), there must be an adjustment code of "L" (SIF differential benefits) and an amount reported in #37.

When the benefit type is "W" (rate with post injury wage earning capacity), there must be an adjustment code of "R" and an amount reported in #37.

SPECIAL PAYMENT:

This code is only necessary when the payment period is pursuant to an award. When interest is being reported, the through date should reflect the date that the accrued benefits were paid.

TOTAL WEEKLY RATE:

This should reflect the amount the employee actually receives per week and should equal the base rate in line 36 plus or minus any adjustments reported in line 37.

The weekly rate should be left blank when the benefit type is “B” (partial wage loss).

FROM DATE:

The effective date for the payment period. Do not include the waiting week for the initial disability period unless benefits were paid for those dates. If benefits covered more than one calendar year, the from date should be January 1 of the current year. This field may be left blank when special payment code is “B” (interest).

THROUGH DATE:

The ending date (current calendar year only) of the rate/benefit type or the payment termination date, whichever applies. If a special payment code of “B” (interest) is being reported, the through date should reflect the date accrued benefits were paid.

TOTAL AMOUNT PAID:

Indicate the total amount paid to the employee for the payment period. This field is required whenever a through date is present. If an overpayment was made but not recouped, the amount actually paid to the employee should be reflected. If partial benefits are being terminated, the total amount paid must be entered in Part D.

YEAR PAID:

Indicate the year the total amount was paid for the payment period reported on the form.

TERMINATION REASON:

When the reason for filing is “C,” “D,” or “G,” (all terminating benefits), the termination reason code is required. Whenever partial benefits are being terminated, a partial payment worksheet must be attached. If the termination reason is “E” (claimant deceased), a death certificate must be attached.

BELOW PART D

ORDER #:

If payments are being made pursuant to an award or voluntary payment form (WC-115), provide the 9 digit order number that is located in the upper right hand corner of all orders mailed out by the Agency.

SPECIFIC LOSS:

If the benefit type code is “C” (specific loss), enter the exact number of specific loss weeks as well as the effective date of the loss. An amputation chart (WC-728) or vision affidavit, whichever is applicable, should also be attached.

OTHER FILING CODES:

If any of the codes used on the form refer to “Other,” the exact reason must be listed here.

#39 Authorized Signature: The signature of an individual authorized to file this form.

#40 Person Handling Claim: Print the name of the individual who is handling the claim.

#41 Telephone Number: Enter the telephone number, including extension, of the individual listed in #40 who is handling the claim.

#42 Date: Enter the date the form was prepared.

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # _____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City		8. State	9. ZIP Code
10. Employer Name				11. Federal ID Number	12. Injury Location Code N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	

PART B

25. Nature of Injury		26. Part of Body	
27. Average Weekly Wage $	28. Discontinued Fringes $	29. Second Employer A.W.W. $	30. Second Employer Discontinued Fringes $
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate $

37. Weekly Adjustments to Base Rate

_____ $_____ _____ $_____ _____ $_____ _____ $_____

_____ $_____ _____ $_____ _____ $_____ _____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

_____ $_____ _____ $_____ _____ $_____ _____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # _____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

PART E – COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT					
B. 80% AFTER-TAX AMOUNT OF (A)					
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT					
D. FICA TAX[1]					
E. STATE INCOME TAX[1]					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED[2]					

[1] Does not apply in all cases. If applicable, include the value of FICA and state income tax using the figures provided in the back of the agency's rate tables corresponding to the year of injury.

[2] Line G = (Line C + D + E) x Line F. (This figure should appear in Part C, Line 37, with the appropriate adjustment code)

SOCIAL SECURITY This section applies to **old age retirement** benefits only. (Enter net benefit with code "B" in Part C, Line 37)

A. MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT	
B. WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)	
C. 50% OF LINE B	
D. 50% OF BASE RATE (Found in Box 36)	
E. IS DATE OF INJURY ON OR AFTER 12/19/11?	☐ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	☐ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D	

UNEMPLOYMENT COMPENSATION

A. NUMBER OF WEEKS AWARDED	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C. SCHEDULED EXPIRATION DATE	
D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F – RATE ADJUSTMENT[3] FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A. AVERAGE WEEKLY WAGE (On front, Line 27)	
B. 80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C. 100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D. GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E. DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to $0, report base rate as adjustment amount in G.	
F. 80% of Line E (Line E multiplied by .8)[3]	
G. AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to $0, no adjustment can be applied.	

[3] For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

Authority: Workers' Disability Compensation Act, R408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

WC-701 FILING CODES

LINE 31 – TAX FILING STATUS

A. Single
B. Single/Head of Household
C. Married/Filing Joint
D. Married/Filing Separate

LINE 35 – REASON FOR FILING

A. Commencing Benefits
B. Change in Weekly Rate
C. Terminating Benefits
D. Commencing and Terminating Benefits
E. Reimbursement by a Fund
F. Reopening Claim
G. Reopening and Closing Claim
H. Yearly Report of Partial Payments
I. Error on Previous Filing

LINE 37 – WEEKLY ADJUSTMENTS TO BASE RATE

A. Wage Continuation Offset (-)
B. Social Security Coordination (-)
C. Pension Offset (-)
D. Unemployment Offset (-)
E. Disability Insurance Offset (-)
F. Self Insurance Offset (-)
G. Other Benefit Coordination (-)
H. Age 65 Reduction (-)
I. Compensation Supplement (+)
J. Advance Payment (-)
K. 30% Appeal Adjustment (-)
L. SIF Differential Benefits (+)
M. Double Compensation (+)
N. Third Party Offset (-)
O. 2 Years Continuous Disability (+)
P. Recoupment of Overpayment (-)
Q. Other
R. Post Injury Wage Earning Capacity (PIWEC) (-)

LINE 38 – REIMBURSEMENT BY A FUND*

A. Silicosis, Dust Disease & Logging Industry Compensation Fund
B. Self-Insurers' Security Fund
C. SIF/Vocationally Handicapped Provisions
D. Other

*Do not report reimbursements received as a result of the 70% or dual employment provisions. This information will be provided to the agency by the Second Injury Fund.

PART D – BASIS OF PAYMENT

A. Voluntary Payment
B. Open Award
C. Closed Award
D. Stipulated Award
E. Compromise
F. Form 115 Voluntary Pay

PART D – BENEFIT TYPE

A. General Disability
B. Partial Wage Loss
C. Specific Loss
D. Permanent Total
E. Death
F. Other
W. Rate with Post Injury Wage Earning Capacity (PIWEC)

PART D – SPECIAL PAYMENT

A. Accrued Benefits
B. Interest
C. 30% Appeal Adjustment
D. Other

PART D – TERMINATION REASON

A. Returned to Work With No Wage Loss
B. Recovered from Disability
C. Award Reversed
D. End of Specific Loss
E. Claimant Deceased (attach death certificate)
F. Closing Out Weekly Due to Redemption
G. Closing Out Weekly Due to Advance Payment
H. Other

Print Reset

REPORT OF ACCRUED BENEFITS

SS# ______________________ DOI ______________ Employee Name _____________________________

Order # ____________________ Basis Payment Code __________ Year Paid _________________________

Benefit Type	Special Payment	Adjusted Rate	From	Through	Total	Variable Rate Factors
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ _______ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ _______ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ _______ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________

Basis of Payment

A = Voluntary Payment
B = Open Award
C = Closed Award
D = Stipulated Award
E = Compromise
F = Form 115 Voluntary Pay

Benefit Type

A = General Disability
B = Partial Wage Loss
C = Specific Loss
D = Permanent Total
E = Death
F = Other
W= Rate with Post Injury Wage Earning Capacity (PIWEC)

Special Payment

A = Accrued Benefits
B = Interest
C = 30% Appeal Adjustment
D = Other

Weekly Adjustments to Base Rate

A = Wage Continuation Offset
B = Social Security Coordination
C = Pension Offset
D = Unemployment Offset
E = Disability Insurance Offset
F = Self-Insurance Offset
G = Other Benefit Coordination
H = Age 65 Reduction
I = Compensation Supplement
J = Advance Payment
K = 30% Appeal Adjustment
L = SIF Differential Benefits
M= Double Compensation
N = Third-Party Offset
O = 2-Years Continuous Disability
P = Recoupment of Overpayment Q
Q = Other
R = Post Injury Wage Earning Capacity (PIWEC)

NATURE OF INJURY CODES

Code	Description
300	Abrasions
183	Abscess
281	Aluminosis - aluminum exposure
100	Amputation or enucleation (loss of an eye)
272	Anemia
282	Anthracosis - coal dust
152	Anthrax
540	Anxiety
283	Asbestosis - asbestos fibers
110	Asphyxia
572	Asthma
274	Asthma, toxic (systemic poisoning)
552	Benign and unspecified tumor
590	Bites, human and non-toxic animal
300	Blisters
272	Blood diseases (includes purpura)
183	Boils
572	Bronchitis
274	Bronchitis, toxic (systemic poisoning)
153	Brucellosis
160	Bruise
130	Burn (chemical)
120	Burn or scald (heat)
260	Bursitis
284	Byssinosis - cotton dust
551	Cancer
183	Carbuncles
562	Carpal tunnel
310	Cartilage, torn
183	Cellulitis
561	Central nervous system
561	Cerebral palsy
510	Cerebrovascular & other circulatory conditions
159	Chicken pox
276	Colitis
520	Complications peculiar to medical care (toxic or non-toxic)
140	Concussion (brain, cerebral)
154	Conjunctivitis (non-toxic)
530	Conjunctivitis, chemical
160	Contusion
160	Crush
170	Cut
950	Damage to prosthetic devices (includes eyeglasses, false teeth, etc.)
540	Depression

Code	Description
200	Electric shock, electrocution
274	Emphysema
240	Environmental heat (does not include sunburn)
260	Epicondylitis
995	Epilepsy
184	Erythema, toxic
530	Eye diseases
210	Fracture
220	Freezing (includes frostbite)
260	Ganglion cyst
276	Gastro-enteritis
276	Gastro-intestinal diseases
273	Hay fever, toxic (systemic poisoning)
230	Hearing loss or impairment
991	Heart attack
991	Heart conditions
240	Heatstroke
320	Hemorrhoids (circulatory system)
330	Hepatitis (serum & infective)
250	Hernia, rupture
190	Herniated disc
159	Herpes
991	Hypertension
150	Infective or parasitic disease, unspecified
572	Influenza
274	Influenza, toxic (systemic poisoning)
294	Ionizing radiation - Isotopes
293	Ionizing radiation - X-Ray
530	Iritis
260	Joints, inflammation or irritation
170	Laceration
551	Leukemia
184	Lichen
530	Loss of vision
551	Malignant tumor
159	Measles
540	Mental disorders
292	Microwave, radiation effects
561	Migraine
995	Miscarriage
400	Multiple injuries
159	Mumps
260	Muscles, inflammation or irritation
562	Nerves and peripheral ganglia (includes Bell's Palsy)

NATURE OF INJURY CODES

Code	Description	Code	Description
540	Derangement, internal	560	Nervous system, conditions of, unspecified
185	Dermatitis, allergenic or contact	540	Neurosis
180	Dermatitis, unspecified	900	No injury or illness
190	Dislocation & dislocated disc	999	Nonclassifiable
110	Drowning	990	Occupational disease (not elsewhere classified)
151	Dysentery, amebiasis	159	Other infective diseases
500	Effects of changes in atmospheric pressure (equilibrium)	995	Other injury, not elsewhere classified
287	Other pneumoconiosis and related diseases	273	Sinusitis, toxic (systemic poisoning)
184	Other skin conditions	189	Skin conditions, unspecified
279	Other toxic effects on one system only	170	Sliver
190	Pinched nerve (back only)	273	Smoke inhalation
310	Pinched nerve (other than back)	310	Sprains
280	Pneumoconiosis & related diseases, unspecified	310	Strains
289	Pneumoconiosis with tuberculosis	110	Strangulation
572	Pneumonia	540	Stress
274	Pneumonia, toxic (systemic poisoning)	510	Stroke
274	Pneumonitis	110	Suffocation
280	Pneumothorax	291	Sunburn, etc. (non-ionizing radiation)
270	Poisoning, systemic, unspecified	240	Sunstroke
271	Poisoning, toxic material	580	Symptoms & ill-defined conditions (e.g., fainting)
183	Primary Infections of the skin	260	Tendinitis
184	Pruritus	260	Tendons, inflammation or irritation
170	Puncture	260	Tenosynovitis, stenosing
290	Radiation effects, unspecified	156	Tetanus
570	Respiratory System, conditions of, unspecified	275	Toxic hepatitis
581	Rhinitis	157	Tuberculosis
273	Rhinitis, toxic (systemic poisoning)	550	Tumor, neoplasm, unspecified
310	Rotator cuff tear	571	Upper respiratory
300	Scratches	510	Varicose veins
285	Siderosis - metallic dust	295	Welder's flash (eyes only)
286	Silicosis - silica dust	310	Whiplash

* When two codes are listed, the first represents nature of injury and the second is part of body

PART OF BODY CODES

Code	Description		Code	Description
410	Abdomen (include internal organs); Hernia, inguinal		350	Fingertip(s)
520	Ankle		530	Foot (not ankle or toe); Metatarsal
310	Arm(s), above wrist, unspecified		315	Forearm; Radius; Ulna
318	Arm, multiple		397	Hand & Finger(s)
319	Arm, not elsewhere classified		330	Hand (not wrist or fingers); Metacarpal
801	Arteries; Blood; Circulatory system; Heart; Veins		198	Head, multiple
420	Back (include back muscles); Coccyx; Lumbar; Sacrum; Spinal cord; Spine		100	Head, unspecified
311	Biceps; Humerus; Triceps; Upper arm		513	Knee; Patella
820	Bladder; Excretory system; Intestines; Kidneys		510	Leg(s) (above ankle), unspecified
800	Body system, unspecified		518	Leg, multiple
830	Bones; Joints; Muscles; Musculo-skeletal system; Tendons		519	Leg, not elsewhere classified
110	Brain; Concussion		144	Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue
430	Breastbone; Chest (internal organs); Pectorals; Ribs; Sternum; Thorax		598	Lower extremities, multiple
440	Buttocks; Hips; Pelvic organs; Pelvis		500	Lower extremities, unspecified
200	Cervical; Neck		850	Lungs; Respiratory system
141	Cheek; Chin; Jaw; Mandible		700	Multiple parts (use when more than one major body part has been affected)
450	Clavicle; Deltoid; Scapula; Shoulder(s)		146	Nasal passages; Nose (includes sense of smell); Sinus
810	Digestive system		999	Nonclassifiable (insufficient information to identify affected part)
121	Ear(s), external		880	Other body systems
124	Ear(s), internal		150	Scalp
120	Ear(s), unspecified		160	Skull
313	Elbow; Olecranon		147	Teeth
840	Epilepsy; Nervous system		540	Toe(s)
130	Eye(s); Eyelid; Optic nerves; Vision		550	Toetip(s)
148	Face, multiple parts		498	Trunk, multiple
149	Face, not elsewhere classified; Forehead		400	Trunk, unspecified
140	Face, unspecified		398	Upper extremities, multiple
511	Femur; Thigh		300	Upper extremities, unspecified
515	Fibula; Lower leg; Tibia		320	Wrist
340	Finger(s)			

List of Form WC-701 Examples

EXAMPLE #	FILING REASON	DESCRIPTION
1	A	Commencing benefits (no adjustments to base rate)
2	A	Commencing benefits (with adjustments to base rate)
3	B	Change in weekly rate due to decrease in dependents
4	C	Terminating benefits
5	D	Commencing and terminating benefits
6	F	Reopening claim
7	G	Reopening and closing claim
8	H	Yearly report of partial payments
9	B	Commencing benefits as the result of an open award
10	E	Reporting a compromised payment
11	D	Change in weekly rate due to reporting of P&T differential benefits
12	A	Rate with post injury wage earning capacity (PIWEC)
13	A	Old-age social security benefits being paid on DOI occurring after 12/19/11
14	A	Old-age social security benefits not being paid on DOI occurring after 12/19/11
15	A	Old-age social security benefits being paid or subsequently paid on DOI occurring before 12/19/11

EXAMPLE #1 – Filing Reason "A"
Commencing benefits (no adjustments to base rate)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	02/03/2007		02/07/2007	

PART B

25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 310.14

37. Weekly Adjustments to Base Rate

_____ $_____ _____ $_____ _____ $_____ _____ $_____

_____ $_____ _____ $_____ _____ $_____ _____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

_____ $_____ _____ $_____ _____ $_____ _____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	02/02/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC_____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	02/12/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #2 – Filing Reason "A"
Commencing benefits (with adjustments to base rate)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	02/03/2007		02/07/2007	

PART B

25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 310.14

37. Weekly Adjustments to Base Rate

A $ 387.68	____ $	____ $	____ $
____ $	____ $	____ $	____ $

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $	____ $	____ $	____ $

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$0.00	02/02/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC_____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	02/12/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #2 – continued

PART E – COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT		$ 450.00			
B. 80% AFTER-TAX AMOUNT OF (A)		$ 310.14			
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT		$ 387.68			
D. FICA TAX[1]					
E. STATE INCOME TAX[1]					
F. % EMPLOYER CONTRIBUTION		100%			
G. INCOME TO BE COORDINATED[2]		$ 387.68			

[1] Does not apply in all cases. If applicable, include the value of FICA and state income tax using the figures provided in the back of the agency's rate tables corresponding to the year of injury.

[2] Line G = (Line C + D + E) x Line F. (This figure should appear in Part C, Line 37, with the appropriate adjustment code)

SOCIAL SECURITY This section applies to **old age retirement** benefits only. (Enter net benefit with code "B" in Part C, Line 37)

A. MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT	
B. WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)	
C. 50% OF LINE B	
D. 50% OF BASE RATE (Found in Box 36)	
E. IS DATE OF INJURY ON OR AFTER 12/19/11?	☐ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	☐ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D	

UNEMPLOYMENT COMPENSATION

A. NUMBER OF WEEKS AWARDED	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C. SCHEDULED EXPIRATION DATE	
D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F – RATE ADJUSTMENT[3] FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A. AVERAGE WEEKLY WAGE (On front, Line 27)	
B. 80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C. 100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D. GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E. DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to $0, report base rate as adjustment amount in G.	
F. 80% of Line E (Line E multiplied by .8)[3]	
G. AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to $0, no adjustment can be applied.	

[3] For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

Authority: Workers' Disability Compensation Act, R408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #3 – Filing Reason "B"
Change in weekly rate

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 North Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	N/A

13. Employer Street Address	14. City	15. State	16. ZIP Code
34310 South Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Insurance Company	999999999

19. Self-Insurer's Service Company Name	20. Service Company ID Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/2007	02/07/2007

PART B

25. Nature of Injury	26. Part of Body
Sprain (310)	Ankle (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	**32. Last Day Worked**	**33. Number of Days in Work Week**	**34. Number of Dependents**
C	02/01/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 310.14

37. Weekly Adjustments to Base Rate

_____ $_____ _____ $_____ _____ $_____ _____ $_____
_____ $_____ _____ $_____ _____ $_____ _____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

_____ $_____ _____ $_____ _____ $_____ _____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	02/02/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC_____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	02/12/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #3 – continued

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___2___

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 North Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	N/A

13. Employer Street Address	14. City	15. State	16. ZIP Code
34310 South Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Insurance Company	999999999

19. Self-Insurer's Service Company Name	20. Service Company ID Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/2007	02/07/2007

PART B

25. Nature of Injury	26. Part of Body
Sprain (310)	Ankle (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	**32. Last Day Worked**	**33. Number of Days in Work Week**	**34. Number of Dependents**
C	02/01/2007	7	2

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
B	$ 303.95

37. Weekly Adjustments to Base Rate

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	02/02/2007	03/12/2007	$ 1,727.92	2007	
A	A		$ 303.95	03/13/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	0315/007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #4 – Filing Reason "C"
Terminating benefits

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	02/03/2007		02/07/2007	

PART B

25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 310.14

37. Weekly Adjustments to Base Rate

_____ $_____ _____ $_____ _____ $_____ _____ $_____
_____ $_____ _____ $_____ _____ $_____ _____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

_____ $_____ _____ $_____ _____ $_____ _____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	02/02/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	02/12/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #4 – continued

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # 2

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 North Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	N/A

13. Employer Street Address	14. City	15. State	16. ZIP Code
34310 South Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Insurance Company	999999999

19. Self-Insurer's Service Company Name	20. Service Company ID Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/2007	02/07/2007

PART B

25. Nature of Injury	26. Part of Body
Sprain (310)	Ankle (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	04/04/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
C	$ 310.14

37. Weekly Adjustments to Base Rate

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	02/02/2007	04/06/2007	$ 2,835.57	2007	A

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # _____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	04/12/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #5 – Filing Reason "D"
Commencing and terminating benefits

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	02/03/2007		02/07/2007	

PART B

25. Nature of Injury		26. Part of Body	
Burn (120)		Arm (310)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
D	$ 310.14

37. Weekly Adjustments to Base Rate

____ $_____ ____ $_____ ____ $_____ ____ $_____
____ $_____ ____ $_____ ____ $_____ ____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $_____ ____ $_____ ____ $_____ ____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	02/02/2007	03/12/2007	$ 1,727.92	2007	A

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	03/13/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #6 – Filing Reason "F"
Reopening claim

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	02/03/2007		02/07/2007	

PART B

25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
D	$ 310.14

37. Weekly Adjustments to Base Rate

_____ $_____ _____ $_____ _____ $_____ _____ $_____
_____ $_____ _____ $_____ _____ $_____ _____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

_____ $_____ _____ $_____ _____ $_____ _____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	02/02/2007	03/12/2007	$ 1,727.92	2007	A

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	03/13/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #6 – continued

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # 2

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 North Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	N/A

13. Employer Street Address	14. City	15. State	16. ZIP Code
34310 South Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Insurance Company	999999999

19. Self-Insurer's Service Company Name	20. Service Company ID Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/2007	02/07/2007

PART B

25. Nature of Injury	26. Part of Body
Sprain (310)	Ankle (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	**32. Last Day Worked**	**33. Number of Days in Work Week**	**34. Number of Dependents**
C	04/04/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
F	$ 310.14

37. Weekly Adjustments to Base Rate

_____ $_____ _____ $_____ _____ $_____ _____ $_____

_____ $_____ _____ $_____ _____ $_____ _____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

_____ $_____ _____ $_____ _____ $_____ _____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	04/05/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	04/12/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #7 – Filing Reason "G"
Reopening and closing claim

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	02/03/2007		02/07/2007	

PART B

25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
D	$ 310.14

37. Weekly Adjustments to Base Rate

____ $_____ ____ $_____ ____ $_____ ____ $_____
____ $_____ ____ $_____ ____ $_____ ____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $_____ ____ $_____ ____ $_____ ____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	02/02/2007	03/12/2007	$ 1,727.92	2007	A

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	03/13/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #7 – continued

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # 2

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
111-22-3333	02/01/2007	Doe, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 North Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	N/A

13. Employer Street Address	14. City	15. State	16. ZIP Code
34310 South Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Insurance Company	999999999

19. Self-Insurer's Service Company Name	20. Service Company ID Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/2007	02/07/2007

PART B

25. Nature of Injury	26. Part of Body
Sprain (310)	Ankle (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	**32. Last Day Worked**	**33. Number of Days in Work Week**	**34. Number of Dependents**
C	04/04/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
G	$ 310.14

37. Weekly Adjustments to Base Rate

_____ $_____ _____ $_____ _____ $_____ _____ $_____

_____ $_____ _____ $_____ _____ $_____ _____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

_____ $_____ _____ $_____ _____ $_____ _____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 310.14	04/05/2007	04/20/2007	$ 708.89	2007	A

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	04/22/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #8 – Filing Reason "H"
Yearly report of partial payments

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	11/04/2007	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	11/08/2007		11/11/2007	

PART B

25. Nature of Injury		26. Part of Body	
Hearing Loss (230)		Ears (124)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	11/04/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 310.14

37. Weekly Adjustments to Base Rate

____ $_____ ____ $_____ ____ $_____ ____ $_____

____ $_____ ____ $_____ ____ $_____ ____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $_____ ____ $_____ ____ $_____ ____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	B			11/05/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	11/14/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #8 – continued

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # 2

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
111-22-3333	11/04/2007	Doe, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 North Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	N/A

13. Employer Street Address	14. City	15. State	16. ZIP Code
34310 South Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Insurance Company	999999999

19. Self-Insurer's Service Company Name	20. Service Company ID Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	11/08/2007	11/11/2007

PART B

25. Nature of Injury	26. Part of Body
Hearing Loss (230)	Ears (124)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 450.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	**32. Last Day Worked**	**33. Number of Days in Work Week**	**34. Number of Dependents**
C	11/04/2007	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
H	$ 310.14

37. Weekly Adjustments to Base Rate

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	B			11/05/2007	12/30/2007	$ 188.03	2007	
A	B			12/31/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # _____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	01/02/2008

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

Workers' Compensation Agency
Verification of Monetary Information
Partial Benefit Rates

For Year: 2007

File Name: John R. Doe

Last Update: 08/01/2012 10:18:44

Prior to Injury

Year of Injury:	2007
Gross Weekly Wage:	$450.00
Discontinued Fringes:	$0.00
Nbr of Dependents:	3
Tax Class:	3
80 Percent Rate	$310.14 (Including fringes)

After Injury

Begin Date	End Date	Year Paid	80% Rate Before Injury	Wages Received	80% Rate After Injury	Partial Rate
11/05/2007	11/11/2007	2007	$310.14	400.00	279.81	30.33
11/12/2007	11/18/2007	2007	$310.14	386.00	271.25	38.89
11/19/2007	11/25/2007	2007	$310.14	450.00	310.14	0.00
11/26/2007	12/02/2007	2007	$310.14	410.00	285.92	24.22
12/03/2007	12/09/2007	2007	$310.14	320.00	230.59	79.55
12/10/2007	12/16/2007	2007	$310.14	425.00	295.10	15.04
12/17/2007	12/23/2007	2007	$310.14	450.00	310.14	0.00
12/24/2007	12/30/2007	2007	$310.14	450.00	310.14	0.00
Grand Totals:						**$188.03**

Number of Weeks: 8

EXAMPLE #9 – Basis of Payment "B"
Open Award
Benefits ordered @ $397.02 per week beginning on 3/12/06; accrued benefits paid on 5/8/07

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
111-22-3333	03/11/2006	Doe, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 North Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	N/A

13. Employer Street Address	14. City	15. State	16. ZIP Code
34310 South Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Insurance Company	999999999

19. Self-Insurer's Service Company Name	20. Service Company ID Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	03/13/2006	05/08/2007

PART B

25. Nature of Injury	26. Part of Body
Heart Attack (991)	Heart (801)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 610.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	**32. Last Day Worked**	**33. Number of Days in Work Week**	**34. Number of Dependents**
C	03/11/2006	7	2

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 397.02

37. Weekly Adjustments to Base Rate

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $ _____ ____ $ _____ ____ $ _____ ____ $ _____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
B	A		$ 397.02	05/09/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # 042007008

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	05/10/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

Print Date: 08/01/2012
Print Time: 11:36:49

Version: 13.0

Workers' Compensation Agency
Verification of Monetary Information
Accrued Payment & Interest

Begin Date	End Date	Paid Date	Comp Rate	Days Worked	Total Weeks	Rem Days	Total Comp	Total Interest	Total Comp & Interest
03/12/2006	05/08/2007	05/08/2007	$397.02	7	60	3	$23,991.35	$1,347.69	$25,339.04
				Grand Totals	**60**	**3**	**$23,991.35**	**$1,347.69**	**$25,339.04**

REPORT OF ACCRUED BENEFITS

SS# 111-22-3333 DOI 03/11/2006 Employee Name Doe, John R.

Order # 042007008 Basis Payment Code B Year Paid 2007

Benefit Type	Special Payment	Adjusted Rate	From	Through	Total	Variable Rate Factors
A	A	$397.02	03/12/2006	05/08/2007	$23,991.35	Deps 2 Base Amt $ 397.02 Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
	B			05/08/2007	$1,347.69	Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________
						Deps ____Base Amt $ ________ Adjustment Code ___ $ ________ Adjustment Code ___ $ ________

Basis of Payment

A = Voluntary Payment
B = Open Award
C = Closed Award
D = Stipulated Award
E = Compromise
F = Form 115 Voluntary Pay

Benefit Type

A = General Disability
B = Partial Wage Loss
C = Specific Loss
D = Permanent Total
E = Death
F = Other
W= Reduced Wage Earning Capacity

Special Payment

A = Accrued Benefits
B = Interest
C = 30% Appeal Adjustment
D = Other

Weekly Adjustments to Base Rate

A = Wage Continuation Offset
B = Social Security Coordination
C = Pension Offset
D = Unemployment Offset
E = Disability Insurance Offset
F = Self-Insurance Offset
G = Other Benefit Coordination
H = Age 65 Reduction
I = Compensation Supplement
J = Advance Payment
K = 30% Appeal Adjustment
L = SIF Differential Benefits
M= Double Compensation
N = Third-Party Offset
O = 2-Years Continuous Disability
P = Recoupment of Overpayment Q
Q = Other
R = Residual Wage Earning Capacity Reduction

EXAMPLE #10 – Basis of Payment "E"
Compromise (rate and termination reason not required)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	02/05/2007	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	02/10/2007		05/02/2007	

PART B

25. Nature of Injury		26. Part of Body	
Inflammation (260)		Hip (440)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
		7	

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
D	$

37. Weekly Adjustments to Base Rate

____ $_____ ____ $_____ ____ $_____ ____ $_____
____ $_____ ____ $_____ ____ $_____ ____ $_____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $_____ ____ $_____ ____ $_____ ____ $_____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
E	A					$ 1,500.00	2007	

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # 042807010

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	05/12/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #11 – Basis of Payment "D"
Permanent Total

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___2____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	10/15/2007	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	10/18/2007		10/21/2007	

PART B

25. Nature of Injury		26. Part of Body	
Industrial Loss of Use		Legs (510)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 226.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
D	10/15/2007	7	2

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
B	$ 161.38

37. Weekly Adjustments to Base Rate

L $ 43.63	____ $ ____	____ $ ____	____ $ ____
____ $ ____	____ $ ____	____ $ ____	____ $ ____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $ ____	____ $ ____	____ $ ____	____ $ ____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
B	A		$ 161.38	10/16/2007	12/31/2007	$ 1,775.18	2007	
B	D		$ 205.01	01/01/2008				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	01/05/2008

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #12 – Filing Reason "A"
Rate with post injury wage earning capacity (PIWEC)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	04/15/2012	Doe, John R.		09/04/1950	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	04/15/2012		04/22/2012	

PART B

25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 850.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	04/15/2012	7	3

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 548.46

37. Weekly Adjustments to Base Rate

R $ 160.00	____ $ ____	____ $ ____	____ $ ____
____ $ ____	____ $ ____	____ $ ____	____ $ ____

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

____ $ ____	____ $ ____	____ $ ____	____ $ ____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	W		$ 388.46	04/16/2012				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	02/12/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #12 – continued

PART E – COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT					
B. 80% AFTER-TAX AMOUNT OF (A)					
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT					
D. FICA TAX[1]					
E. STATE INCOME TAX[1]					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED[2]					

[1] Does not apply in all cases. If applicable, include the value of FICA and state income tax using the figures provided in the back of the agency's rate tables corresponding to the year of injury.

[2] Line G = (Line C + D + E) x Line F. (This figure should appear in Part C, Line 37, with the appropriate adjustment code)

SOCIAL SECURITY This section applies to **old age retirement** benefits only. (Enter net benefit with code "B" in Part C, Line 37)

A. MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT	
B. WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)	
C. 50% OF LINE B	
D. 50% OF BASE RATE (Found in Box 36)	
E. IS DATE OF INJURY ON OR AFTER 12/19/11?	☐ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	☐ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D	

UNEMPLOYMENT COMPENSATION

A. NUMBER OF WEEKS AWARDED	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C. SCHEDULED EXPIRATION DATE	
D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F – RATE ADJUSTMENT[3] FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A. AVERAGE WEEKLY WAGE (On front, Line 27)	$ 850.00
B. 80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	$ 548.46
C. 100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	$ 685.58
D. GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	$ 200.00
E. DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to $0, report base rate as adjustment amount in G.	$ 485.58
F. 80% of Line E (Line E multiplied by .8)[3]	$ 388.46
G. AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to $0, no adjustment can be applied.	$ 160.00

[3] For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

Authority: Workers' Disability Compensation Act, R408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #13 – Filing Reason "A"
Old-age social security benefits being paid on DOI occurring after 12/19/11

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	12/20/2011	Doe, John R.		03/04/1949	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	12/20/2011		12/27/2011	

PART B

25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 650.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	12/20/2011	7	1

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 416.89

37. Weekly Adjustments to Base Rate

B	$ 208.45		$		$		$
	$		$		$		$

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

	$		$		$		$

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 208.44	12/21/2011				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	12/27/2011

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #13 – continued

PART E – COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT					
B. 80% AFTER-TAX AMOUNT OF (A)					
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT					
D. FICA TAX[1]					
E. STATE INCOME TAX[1]					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED[2]					

[1] Does not apply in all cases. If applicable, include the value of FICA and state income tax using the figures provided in the back of the agency's rate tables corresponding to the year of injury.

[2] Line G = (Line C + D + E) x Line F. (This figure should appear in Part C, Line 37, with the appropriate adjustment code)

SOCIAL SECURITY This section applies to **old age retirement** benefits only. (Enter net benefit with code "B" in Part C, Line 37)

A. MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT	$ 2,100.00
B. WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)	$ 484.99
C. 50% OF LINE B	$242.50
D. 50% OF BASE RATE (Found in Box 36)	$ 208.45
E. IS DATE OF INJURY ON OR AFTER 12/19/11?	☒ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	☒ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D	$208.45

UNEMPLOYMENT COMPENSATION

A. NUMBER OF WEEKS AWARDED	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C. SCHEDULED EXPIRATION DATE	
D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F – RATE ADJUSTMENT[3] FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A. AVERAGE WEEKLY WAGE (On front, Line 27)	
B. 80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C. 100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D. GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E. DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to $0, report base rate as adjustment amount in G.	
F. 80% of Line E (Line E multiplied by .8)[3]	
G. AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to $0, no adjustment can be applied.	

[3] For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

Authority: Workers' Disability Compensation Act, R408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #14 – Filing Reason "A"
Old-age social security benefits not being paid on DOI occurring after 12/19/11

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	12/20/2011	Doe, John R.		03/04/1949	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	12/20/2011		12/27/2011	

PART B

25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 650.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	12/20/2011	7	1

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 416.89

37. Weekly Adjustments to Base Rate

B	$ 242.50		$		$		$
	$		$		$		$

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

	$		$		$		$

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 174.39	12/21/2011				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	12/27/2011

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #14 – continued

PART E – COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT					
B. 80% AFTER-TAX AMOUNT OF (A)					
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT					
D. FICA TAX[1]					
E. STATE INCOME TAX[1]					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED[2]					

[1] Does not apply in all cases. If applicable, include the value of FICA and state income tax using the figures provided in the back of the agency's rate tables corresponding to the year of injury.

[2] Line G = (Line C + D + E) x Line F. (This figure should appear in Part C, Line 37, with the appropriate adjustment code)

SOCIAL SECURITY This section applies to **old age retirement** benefits only. (Enter net benefit with code "B" in Part C, Line 37)

A. MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT	$ 2,100.00
B. WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)	$ 484.99
C. 50% OF LINE B	$ 242.50
D. 50% OF BASE RATE (Found in Box 36)	$208.45
E. IS DATE OF INJURY ON OR AFTER 12/19/11?	☒ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	☐ YES ☒ NO
IF NO – COORDINATE AMOUNT IN LINE C	$ 242.50
IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D	

UNEMPLOYMENT COMPENSATION

A. NUMBER OF WEEKS AWARDED	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C. SCHEDULED EXPIRATION DATE	
D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F – RATE ADJUSTMENT[3] FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A. AVERAGE WEEKLY WAGE (On front, Line 27)	
B. 80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C. 100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D. GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E. DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to $0, report base rate as adjustment amount in G.	
F. 80% of Line E (Line E multiplied by .8)[3]	
G. AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to $0, no adjustment can be applied.	

[3] For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

Authority: Workers' Disability Compensation Act, R408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #15 – Filing Reason "A"
Old-age social security benefits being paid or subsequently paid on DOI occurring before 12/19/11

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING # ___1____

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)		4. Date of Birth	5. Date of Death
111-22-3333	12/07/2011	Doe, John R.		03/04/1949	
6. Employee Street Address		7. City		8. State	9. ZIP Code
123 North Elm Street		Lansing		MI	48910
10. Employer Name				11. Federal ID Number	12. Injury Location Code
Smith's Auto Repair				38-1111111	N/A
13. Employer Street Address		14. City		15. State	16. ZIP Code
34310 South Baker Street		Lansing		MI	48915
17. Carrier or Self-Insured Name				18. NAIC or Self-Insured Number	
United States Insurance Company				999999999	
19. Self-Insurer's Service Company Name				20. Service Company ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made	
48912	D12345-1	12/20/2011		12/27/2011	

PART B

25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$ 650.00	$ 0.00	$	$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	12/20/2011	7	1

PART C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$ 416.89

37. Weekly Adjustments to Base Rate

B	$ 242.50		$		$		$
	$		$		$		$

38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)

	$		$		$		$

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		$ 174.39	12/21/2011				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #_____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS _____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	12/27/2011

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #15 – continued

PART E – COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT					
B. 80% AFTER-TAX AMOUNT OF (A)					
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT					
D. FICA TAX[1]					
E. STATE INCOME TAX[1]					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED[2]					

[1] Does not apply in all cases. If applicable, include the value of FICA and state income tax using the figures provided in the back of the agency's rate tables corresponding to the year of injury.

[2] Line G = (Line C + D + E) x Line F. (This figure should appear in Part C, Line 37, with the appropriate adjustment code)

SOCIAL SECURITY This section applies to **old age retirement** benefits only. (Enter net benefit with code "B" in Part C, Line 37)

A. MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT	$ 2,100.00
B. WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)	$484.99
C. 50% OF LINE B	$242.50
D. 50% OF BASE RATE (Found in Box 36)	$208.45
E. IS DATE OF INJURY ON OR AFTER 12/19/11?	☐ YES ☒ NO
IF NO – COORDINATE AMOUNT IN LINE C	$ 242.50
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	☐ YES ☐ NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D	

UNEMPLOYMENT COMPENSATION

A. NUMBER OF WEEKS AWARDED	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C. SCHEDULED EXPIRATION DATE	
D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F – RATE ADJUSTMENT[3] FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A. AVERAGE WEEKLY WAGE (On front, Line 27)	
B. 80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C. 100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D. GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E. DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to $0, report base rate as adjustment amount in G.	
F. 80% of Line E (Line E multiplied by .8)[3]	
G. AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to $0, no adjustment can be applied.	

[3] For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

Authority: Workers' Disability Compensation Act, R408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801